Please print out, fill out and bring with you the day of your appointment

PATIENT DATA

First Name:		Social Security#:	
Middle Initial:		Date of Birth:	
Last Name:		Age:	
Nickname:		Gender:	○ Male ○ Female

Organization:		Building/Room:	
Mail Code:		Shift:	○ 1 ○ 2 ○ 3 ○ TDY
Work Phone:		Job Description:	
Home Phone:		Supervisor's Name:	
E-mail:	○ Yes ○ No	Supervisor's Phone:	

Have you ever been to RehabWorks before?: ○ Yes ○ No

If YES, please give approximate date/year: _____

Place injured: ○ Home ○ Work ○ Sport ○ Other

Is this a Workers' Comp Injury: ○ Yes ○ No

If so, please complete the following:

Workers' Comp Name:	
Workers' Comp Phone:	
Workers' Comp Fax:	

ONLY SIGN BELOW IF THIS IS A WORKERS' COMP INJURY:

Statement of Consent for Release of Information

I authorize RehabWorks to release the medical information contained in my patient records pertaining to the workers' compensation injury for which I am currently being treated by RehabWorks to my physician and/or workers' compensation representative for the purpose of progress notes and/or case management.

Employee Signature _____ **Date** _____

RehabWorks
KENNEDY SPACE CENTER

Medical History Form

biomotics
VISION • VALUE • INTEGRITY

Name: _____

Do you currently have or have you had problems with:

	Please select one		Please provide details:
ANGINA/CHEST PAIN	◯ Yes	◯ No	
ARTHRITIS Area:	◯ Yes	◯ No	
ASTHMA	◯ Yes	◯ No	
BACK INJURY	◯ Yes	◯ No	
BALANCE PROBLEMS	◯ Yes	◯ No	
BLACKOUT/FAINTING	◯ Yes	◯ No	
BLEEDING PROBLEMS	◯ Yes	◯ No	
BLOOD CLOTS OR PHLEBITIS Area:	◯ Yes	◯ No	
BONE FRACTURES Area: 1 _____ 2 _____ 3 _____ 4 _____	◯ Yes	◯ No	
CANCER Area:	◯ Yes	◯ No	
CARDIAC CATHETERIZATION	◯ Yes	◯ No	
COUGH	◯ Yes	◯ No	
DIABETES Type:	◯ Yes	◯ No	
DISLOCATION/SUBLUXATION Area: 1 _____ 2 _____ 3 _____	◯ Yes	◯ No	
EPILEPSY/SEIZURES	◯ Yes	◯ No	
GOUT Area:	◯ Yes	◯ No	
HEART ATTACK	◯ Yes	◯ No	
HEART FAILURE	◯ Yes	◯ No	
HEART MURMUR	◯ Yes	◯ No	
HEART VALVE PROBLEMS	◯ Yes	◯ No	
HEARTBURN	◯ Yes	◯ No	
HEPATITIS/JAUNDICE	◯ Yes	◯ No	
HERNIAS Area:	◯ Yes	◯ No	
HIGH BLOOD PRESSURE	◯ Yes	◯ No	
INFECTIOUS DISEASE	◯ Yes	◯ No	
MIGRAINES/HEADACHES	◯ Yes	◯ No	
MOTOR VEHICLE ACCIDENT	◯ Yes	◯ No	
NECK INJURY Area:	◯ Yes	◯ No	
NUMBNESS/TINGLING Area:	◯ Yes	◯ No	
OSTEOPOROSIS	◯ Yes	◯ No	
PALPITATIONS	◯ Yes	◯ No	
PREDNISONE USAGE	◯ Yes	◯ No	
PRIOR CARDIAC SURGERY	◯ Yes	◯ No	

MEDICAL HISTORY FORM (cont)

PROSTATE/KIDNEY PROBLEM	◯ Yes	◯ No	
SCOLIOSIS	◯ Yes	◯ No	
SHORTNESS OF BREATH	◯ Yes	◯ No	
SPRAIN Area: 1 _____ 2 _____ 3 _____ 4	◯ Yes	◯ No	
STOMACH ULCERS	◯ Yes	◯ No	
STRAIN Area: 1 _____ 2 _____ 3 _____ 4	◯ Yes	◯ No	
STROKE	◯ Yes	◯ No	
TUBERCULOSIS	◯ Yes	◯ No	
OTHER	◯ Yes	◯ No	

Injury History

Date of injury: _____

How did your injury occur (describe briefly):

_____

_____

Medications ☐ N/A

Please list any prescription or over-the-counter medicines that you are currently taking:

_____

_____

Allergies ☐ NKA (No Known Allergies)

Please list any known allergies:

_____

_____

Past Surgical History

	Surgery:	Year:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Smoking History

Currently Smoking? ☐ Yes ☐ No _____ packs/day for _____ year(s)

Quit Smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ > 10 years

Previously Smoked _____ packs/day for _____ year(s)

Exercise History Please select one:

◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

Medical Hx Reviewed by _____ **ATC/L** **Injury #:** _____ **Date** _____